# MENTAL HEALTH SERVICES ACT
# STATEMENT OF QUALIFICATIONS SHORT FORM
# BID # DMH111505B1

Proposer Name: _____ Date: _____

**Please note the following:**

1) **All details about this Request For Statement of Qualifications are available at: http://lacdmh.lacounty.gov/ToolsForAdministrators/Agency_Administration/current_open_solicitations.html.**
2) **If you currently have a mental health contract with the Department of Mental Health (DMH), you are eligible to file this updated Statement of Qualifications (SOQ) Short Form in response to DMH's Mental Health Services Act (MHSA) Request for Statement of Qualifications (RFSQ) No. DMH111505B1.**
3) **If you have previously submitted this form and do not wish to make any changes at this time, there is no need to re-submit the form. This form can be re-submitted/revised if necessary at any future date.**
4) **If you want to add new service categories, please mark only the new categories and submit the form with any applicable supporting documentation (program narrative).**

1. Please check the appropriate box if you are currently a DMH provider as a:
   - ☐ a. Legal Entity/Mental Health Services provider — Contract No. _____
   - ☐ b. Legal Entity/Institution for Mental Disease (IMD) provider — Contract No. _____
   - ☐ c. Fee-For-Service Individual or Group provider — Contract No. _____
   - ☐ d. Consultant provider - please describe: _____ — Contract No. _____
   - ☐ e. Other provider or N/A - please describe: _____ — Contract No. _____

2. Please check the appropriate box pertaining to a Settlement Agreement with DMH:
   - ☐ **No**, **I do not** have a current Settlement Agreement with DMH.
   - ☐ **Yes**, **I do** have a current Settlement Agreement with DMH and I am aware that there is a moratorium on expansion and/or implementation of any new programs during the Settlement Agreement's repayment period, and that any exemption from this penalty requires justification that this restriction will negatively impact planned program services.

3. Please check all categories of service where you have experience demonstrating that you meet the requirements under one or more of the following service categories as detailed in RFSQ Section 1.3.1. Please note that service categories 1, 1a, 2, 3, 4a, 5, and 6, require a program narrative that does not exceed two (2) pages/per service category, category 20a requires a program narrative that does not exceed four (4) pages, category 22a requires a summary of an evaluation your agency completed of the impact a community-based partnership had on the community as a whole or on specific individuals within the community, and category 23a requires a program narrative that does not exceed two (2) pages.

   - ☐ 1. Full Service Partnerships (FSP)
     - ☐ a. FSP Enhanced Specialized Foster Care Mental Health Services
   - ☐ 2. IMD Step-Down
   - ☐ 3. Respite Care (In-home)
   - ☐ 4. Housing Related Supportive Services
     - ☐ a. Housing Trust Fund Program
   - ☐ 5. Transitional Age Youth (TAY) Supportive Employment Services
   - ☐ 6. Adult Employment Services
     (**Categories of Service 1, 1a, 2, 3, 4a, 5 and 6 require a program narrative that does not exceed two (2) pages**)
   - ☐ 7. Peer support, peer counseling, and peer mentoring services
   - ☐ 8. Counseling, assessment, and other traditional mental health services (clinic and/or field-based)
   - ☐ 9. Alternative crisis services
   - ☐ 10. Bridging and support services
   - ☐ 11. Workforce training and development
   - ☐ 12. Drop-In Center (TAY only)
   - ☐ 13. Housing – Emergency Vouchers and Project-based Subsidiaries (TAY only)
   - ☐ 14. Integrated Services for Co-Occurring MH & Substance Abuse Disorders (COD) (Children only)
   - ☐ 15. Probation Camp Services (TAY only)
   - ☐ 16. Wellness Centers/Client Run Centers
   - ☐ 17. Professional Development and Consultation Program for Integrated Services for COD and HIV/AIDS

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- ☐ 18. Older Adult Certificate Training Program
- ☐ 19. Workforce Education and Training Plan (WET)
  - ☐ a. Regional Partnership
- ☐ 20. Prevention and Early Intervention Plan (PEI)
  - ☐ a. PEI Mental Health Services for Blind/Visually Impaired Persons (**include a program narrative that does not exceed four (4) pages**)
- ☐ 21. Under-Represented Ethnic Populations (UREP)
- ☐ 22. Innovations (INN)
  - ☐ a. INN Evaluation Component (**include a summary of an evaluation your agency completed of the impact a community-based partnership had on the community as a whole or on specific individuals within the community**)
- ☐ 23. Community Services and Supports Plan (CSS)
  - ☐ a. CSS Family Resource Center (**include a program narrative that does not exceed two (2) pages**)

4. Please check all target age groups with whom you have recent experience. You will be considered only for target groups checked.

☐ 1. Children (0-15)
☐ 2. TAY (16-25)
☐ 3. Adults (26-59)
☐ 4. Older Adults (60 Years +)

5. Please check all Service Areas where you provide services and those Service Areas where you do not currently provide services but have an interest in providing services. You will be considered only for Service Areas checked.

☐ 1. Service Area 1
☐ 2. Service Area 2
☐ 3. Service Area 3
☐ 4. Service Area 4
☐ 5. Service Area 5
☐ 6. Service Area 6
☐ 7. Service Area 7
☐ 8. Service Area 8
☐ 9. Countywide

6. Proof of Insurance is attached to this SOQ – check appropriate boxes

☐ a. Original certificate of insurance
☐ b. 30-day notice of cancellation
☐ c. Certificate of insurance with Los Angeles County as additional insured
☐ d. AM Best Insurer Financial Rating not less than A

6A. <u>General Liability</u> – check appropriate boxes

☐ a. General aggregate $2 mil coverage
☐ b. Products/Completed Operation aggregate $1 mil coverage
☐ c. Personal and Advertising Injury $1 mil coverage
☐ d. Each occurrence $1 mil coverage

6B. <u>Auto Liability</u>

☐ a. Proof of insurance on ISO policy form CA 00 01 with a limit of liability of $1 million for each accident

6C. <u>Workers' Compensation</u> – check appropriate boxes

☐ a. Each accident $1 mil coverage/accident
☐ b. Disease – policy limit $1 mil coverage
☐ c. Disease – each employee $1 mil coverage
☐ d. Letter stating no employees (if applicable)
☐ e. Letter stating compliance with workers' compensation law for another state (if applicable)

6D. <u>Professional Liability</u>

☐ Liability from any error, omission, negligent or wrongful act of the Contractor, its officers or employees with limits of not less than $1 million per occurrence and $3 million aggregate

6E. <u>Property Coverage</u>

☐ Such insurance shall be endorsed naming the County of Los Angeles as loss payee, provides deductibles of no greater than 5% of the property value, and shall be for the full replacement value of County-owned or leased property

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7. Proposer is registered on the County's WebVen accessed at http://doingbusiness.lacounty.gov/main_db.htm or at http://camisvr.co.la.ca.us/webven/.

☐ Yes, my WebVen Registration No. is: _____

☐ Please check if you understand and agree that submission of this SOQ and the signed signature page of the Master Agreement/Amendment constitutes acknowledgement and acceptance of, and a willingness to comply with, all terms and conditions of Appendix H-A – Master Agreement/Amendment should a contract be eventually awarded by the County to provide services. Neither the RFSQ nor this SOQ constitutes a Request for Proposal, Request for Services or an offer of a contract.

Please sign and attach to this SOQ Short Form the service category narrative(s) or summary, Settlement Agreement justification (if applicable), and all required forms listed under the RFSQ's Appendix A, Exhibits 1 through 12. Incomplete forms or forms lacking necessary documentation will not be considered.

On behalf of _____,
(Proposer's Name)

I _____ certify that all statements
(Name of Proposer's Authorized Official)

made in this SOQ submitted by my organization are true and complete to the best of my knowledge and belief. I understand that any false statement(s) of material facts or omissions may subject me to disqualification.

_____
Proposer Name:

_____ _____
E-mail Address: Telephone:

_____
Authorized Official's Printed Name and Title:

_____ _____
Authorized Official's Signature: Date:

Please submit the completed form to:

**Stella Krikorian, Administrative Services Manager III**
**Contracts Development and Administration Division**
**Los Angeles County Department of Mental Health**
**550 S. Vermont Ave., 5th Floor, Room 500**
**Los Angeles, CA 90020**